EXPANDING CONSUMER CHOICE OF HEALTH PLANS
FINDINGS AND RECOMMENDATIONS

I. PRINCIPLES

Choice of health plan (i.e., health insurance arrangements offered by an insurer, employer, health maintenance organization (HMO), or other managed care organization, also known as health benefits financial intermediaries) at the individual or family level is very important to a satisfactory competitive managed health care system (1) to enable a choice of providers, (2) to maintain ongoing provider-patient relationships, (3) to facilitate patient willingness to work with his or her provider, (4) to improve consumer satisfaction with health plans and the health system (studies show that people with choice are more satisfied), and (5) to allow competition to discipline price.

For these reasons, ideally every individual or family should have a choice of multiple health plans that includes a variety of HMOs, PPOs, and other options such as is provided to state and other public agency employees participating in the California Public Employees Retirement System. Achieving the full benefits of competition would also require every individual and family to have economic responsibility for premium price differences, comparative quality information, and some standardization of benefits.

II. CHOICE IN CALIFORNIA TODAY

In California today, more employed individuals have choice of plans than the national average, though fewer employees of smaller firms have choices than employees of larger firms, according to KPMG Peat Marwick data. Even though Californians have greater choice of plans than the national average, fewer working Californians have access to a health plan that provides unlimited choice of provider than workers nationally. In addition, where employees have a choice of plan, it is often a choice of plan model type. This is positive in that some individuals in a group might prefer, for example, an HMO, while others prefer a PPO. However, choices among plan model types may not set up a very competitive situation among health plans because individuals are less willing to switch among them than among plans of the same model type.

III. OBSTACLES TO CHOICE

Individuals (not in groups) theoretically have an unlimited choice of coverage options, so long as they are willing to shop around for it and pay the market price. However, in practice their choice may be much more limited due to reasons of access (e.g., plans often will not sell individual policies to unhealthy or high risk individuals). It has proved to be particularly difficult to guarantee access to coverage to unaffiliated individuals in a system of voluntary health insurance because of the problem of adverse selection and attendant premium “death spirals”.

Employers in the small group market typically offer choice of plan least often because: (1) some health plans refuse to participate in multiple choice situations with small employers, (2) employers face additional administrative burden when offering multiple plans, and (3) employers prefer to offer their whole group in exchange for the best rates

possible today, even though this weakens the health plan's incentive to reduce rates in the future.

In 1993, AB 1672 established rules in the small group market in response to problems of access to choice of plans. While some have suggested that an expansion of these rules to the mid-size market (groups of 51-100) would encourage formation of purchasing groups and ensure a wider array of choices to employment groups[1], there is not a clear consensus that access to coverage options is a major problem in the mid-size market. Such restrictions may reduce the current choice of product designs available in the mid-size market if health plans sought to avoid the requirement to distribute information on all products to all employers. In addition, increased regulation of health plans in this market could encourage more employers to self-insure, enabling them to avoid all state regulation of their health benefits.

IV. PURCHASING GROUPS

One way to expand choice of plans is to expand access to purchasing groups. Purchasing groups act like sophisticated benefits managers of large corporations for multiple employers. They facilitate multiple choice of plan at the individual or family level.

The HIPC, established in 1993 through AB 1672, is a state-run purchasing alliance for small employers with between two and 50 employees, specifically designed to address the administrative problems small employers have in offering multiple choice. However, HIPC growth has been disappointing relative to the small group market. Theories abound about the reasons behind the limited growth of the HIPC. They include: (1) insufficient or inappropriate marketing effort; (2) lack of broker/agent support; (3) purchasing groups are a new idea, the virtues of which may not be well appreciated or understood by many; and (4) the HIPC may offer too much choice which may be overwhelming to some.

With existing purchasing group activity, California has more employees in purchasing groups than any other state. However, despite this activity, purchasing groups are not available in many segments of the market.

Marketing groups that testified to the Task Force indicated that the regulatory hurdles are high to become a purchasing group through the Department of Corporations.[2] Challenges arise because employers contracting with health plans through a purchasing group must contract with each plan separately, health plans participating in purchasing groups can not jointly file coordinated documents with the regulatory authority, rather each plan must file separately, and participating plans are required to disclose to employers and employees details of all the benefit packages they offer even if an employer only wants to offer a few.

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[1] California Association of Health Underwriters, "Questions and Answers About CAHU's Position on SB-393/SB-1281, May 7, 1997.

[2] Testimony presented by and received from Benefits Alliance and California Choice.

V. TASK FORCE RECOMMENDATIONS

While expanding consumer choice is a widely-supported goal among task force members and the public, there is little consensus about how to accomplish it.

A. Ways to Expand Choice of Plan

Change ERISA to Require Employers to Offer Choice

One way for the State to address the problem of the lack of individual choice would be to require employers over some size (e.g., 25 employees) to offer choices, as the federal government did in 1973 through a now-expired provision of the Federal HMO Act. States, such as Maryland, have been trying to do so, but have been blocked by the federal Employee Retirement Income Security Act of 1974 (ERISA) in which the federal government has preempted state regulation of employee benefits.

(1) The Task Force recommends that the US Congress create a new law, like the provision of the original HMO Act, that requires employers to offer choice of plans, which may be satisfied by purchasing through a purchasing group, or modify ERISA to allow California to do so.

Establish Rules Regarding Minimum Participation Requirement

Today, many health plans effectively prohibit some employers, typically small employers, from offering a choice of plans by imposing minimum participation requirements. In other words, a health plan carrier can require that at least, say, 70% of an employers' employees join its plan (i.e., choose one of the products the plan offers through that employer). Health plan carriers employ this policy, in part, to protect themselves from any potential harmful effects of adverse selection within the group. However, this strategy also prevents employees of small employers from having a choice of plans. Current law (AB 1672) combats blatant use of minimum requirements for the purpose of skimming healthy enrollees by requiring health plan carriers to consistently apply their minimum participation policy.

(2) The Task Force recommends that the State prohibit health plans serving the small group market from setting minimum participation requirements for participation in their plans, thereby effectively declining to participate in multiple choice situations.

(a) Instead, an aggregate participation requirement for all carriers offered should be permitted to protect against adverse selection.

(b) This recommendation should only be implemented to the degree that negative consequences such as increasing prices or skimming can be avoided. For example, it may not be appropriate to apply the recommendation in cases where an employer selects carriers that do not offer the same product types (i.e., HMO, PPO, etc.) and where the benefits are not reasonably comparable.

(c) This would not prohibit an employer from offering one plan only (though Recommendation (1) above would).

(d) Nothing should prohibit a health plan from offering a higher price than it would for covering a higher proportion of an employer's group, nor from offering a higher price to a smaller group, within current rating laws.

B. Ways to Expand Purchasing Groups

Simplify the Regulatory Approval Process

(3) The Task Force recommends that the State should make it a matter of public policy to facilitate and encourage the development of purchasing groups for small and medium size employers. The applicable regulatory authority should work continuously to simplify the process of and eliminate barriers to purchasing group formation. Appropriate measures for the DOC and DOI may vary.

EXPANDING CONSUMER CHOICE OF HEALTH PLANS
BACKGROUND PAPER

I. PRINCIPLES

Choice of health plan (i.e., health insurance arrangements offered by an insurer, employer, health maintenance organization (HMO), or other managed care organizations, also known as health benefits financial intermediaries) at the individual or family level is very important to a satisfactory competitive managed health care system for several reasons.

A. Enable Choice of Providers

First, the individual provider-patient relationship is such an important and intensely personal one that most people understandably place a very high value on choice of provider (i.e., doctor or other appropriately-licensed health professionals operating within their scope of practice). In managed care, health insurance is usually linked to a specific limited set of providers. Each plan contracts selectively with a panel of providers. While many health plans contract with largely open-ended networks, to assure people that they are likely to be able to be covered for the services of the providers they prefer, people need to be offered either a wide range of plans or health plans that have nearly all-encompassing networks. (For a discussion of all-encompassing networks, see below.)

B. Maintain Ongoing Provider-Patient Relationships

Second, and related, if an individual does not have a wide choice of plans or access to a health plan with a wide network, switching plans is likely to mean switching providers. According to a recent national survey, of those changing managed care plans, 39% had to change doctors.[3] For patients with ongoing relationships with providers, this would mean disruption of the relationship, inconvenience and unhappiness. For providers who have ongoing relationships with patients, switching often means a loss to the patient of extensive knowledge of his or her condition and history. These relationships are expensive (in terms of visits, diagnostic tests, etc.) and time-consuming to replicate. In addition, preliminary studies suggest that long-standing physician-patient relationships are associated with less hospitalization and lower health care costs.[4]

C. Facilitate Patient Willingness to Work With Providers

Third, it can be hard for a provider to establish a good provider-patient relationship with a patient who has not chosen that provider or prefers to see another provider outside the plan. This explains the historic position of HMOs that members should have choice of plan.[5]

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[3] Karen Davis and Cathy Schoen, "Managed Care, Choice, and Patient Satisfaction", New York: The Commonwealth Fund, August 1997.

[4] Linda J. Weiss and Jan Blustein, "Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans," *American Journal of Public Health*, 86:1742-1747, 1996.

[5] Somers AR, *The Kaiser-Permanente Medical Care Program*, New York: Commonwealth Fund, 1971.

D. Improve Consumer Satisfaction with Health Plans and the Health System

Fourth, consumer satisfaction, with health plans and with the health system as a whole, is likely to be much higher if people have a choice of plan. Different health plans have different operating rules, some of which will be burdensome to some, acceptable to others. For example, one HMO might require women to have a referral from their primary care provider for every visit to the obstetrician-gynecologist while in another the standard practice might be for primary care providers to make standing referrals. People with preferences will be happier with choices. Moreover, if people do not have choice of plan, market forces will not have an opportunity to force the plans with unpopular practices to change. If people are forced into a plan by an employer, they are more likely to be unhappy with the plan and, by association, with the health care system in general. Today, in California, 46% of employees do not have a choice of plan.[6] If instead, people have a menu of options and make a choice, they are more likely to accept some responsibility for that choice and to show greater tolerance if problems occur. Indeed, the Kaiser/Commonwealth National Health Insurance Survey indicates that having a choice of plans is linked to satisfaction with services, choice of physicians, and insurance plans. Those in managed care who did not have a choice of plans were almost twice as likely to be dissatisfied with their insurance plans; 22% were very or somewhat dissatisfied with their insurance plans compared to 14% of those with a choice.[7]

Adults in Managed Care Plans Ages 18-64
Somewhat or Very Dissatisfied with Plan or Patient Care

	Total	With Choice	No Choice
Insurance plan	17%	14%	22%
Choice of doctors	15%	13%	18%
Care received	14%	13%	16%

Source: Davis and Schoen, "Managed Care, Choice, and Patient Satisfaction", New York: The Commonwealth Fund, August 1997.

E. Allow Competition to Discipline Price

Fifth, for competition to work to discipline price, demand for health insurance must be price-elastic, i.e. if a seller lowers price by X%, it must attract more than an X% increase in the number of customers to offset the revenue loss associated with lowering price. Increasing the incentive for health plans to lower price requires individual choice of plan. If there is only group choice of plan, the whole group must be persuaded to change plans to take advantage of a lower price offered by another plan. Some members of the group are likely to have strong provider-patient relationships and be unwilling to change (unless the new plan offers the same providers, which can happen). If there is individual choice of plan, those individuals who are willing to change for better value can do so, and make it worthwhile for the competitor to lower price. A key component to making this strategy work to create price-elastic demand is economic responsibility of

[6] Kelly Hunt, KPMG Peat Marwick, Analysis conducted for the California Managed Health Care Improvement Task Force, Tysons Corner, VA: 1996.
[7] Davis, Schoen, 1997.

the individuals making the choices for premium price differences. In addition, standardization of benefits and comparative quality information helps to facilitate choices by making it easier to compare alternatives.

Alternatively, there could be an incentive for health plans to offer lower prices with group choice if the choices available were among plans with similar, broad networks of providers, as is the case among many plans in California today. On average, physicians in California contract with 15 managed care plans.[8] The principal basis upon which to choose a plan under these circumstances would be price because people would not have to change providers when they changed plan. In this case, it would be easier to change plan to get better value. The trouble with this model is that it does not create price competition among medical groups where most decisions about spending are made and thus with which the potential for cost savings lie. In this model, a medical group cannot attract more customers by cutting price. This mitigates pressure on medical groups to hold down costs. Moreover, if the health plan must try to be all-inclusive, then by definition it will include inefficient as well as efficient providers. The need to be all-encompassing weakens a health plan's ability to select providers based on quality and to conduct value-based contract negotiations.

For these reasons, ideally every individual or family should have a choice of multiple health plans that includes a variety of HMOs, PPOs, and other options such as is provided to state and other public agency employees participating in the California Public Employees Retirement System (CalPERS). Achieving the full benefits of competition would also require every individual and family to have some economic responsibility for premium price differences, comparative quality information, and some standardization of benefits.

There is a tension between standardization of benefits to facilitate comparison and wide product choice. Complete standardization would most simplify comparison, but would eliminate product choice and would block innovation. On the other hand, no standardization would allow wide choice of products, but would make plan comparison more difficult. In addition, where products compete, less restrictive plans (e.g., PPOs and POS plans) suffer from adverse risk selection (i.e., sicker people choose them to ensure they can obtain care from out-of-network specialists, causing prices to escalate). Risk adjustment can level the playing field. However, the greater the variation among plans, the more difficult it is to risk adjust.

II. CHOICE IN CALIFORNIA TODAY

California's record with regard to individual choice of plan is mixed. Of the working population in California whose employers provide health care coverage, 54.5% of employees have a choice of two or more plans. In comparison, only 48.2% of employees nationally have a choice of plans. This implies that California is doing slightly better than average in providing choice of plans to consumers.

[8] American Medical Association, "Number of Managed Care Contracts per Practice, 1996", *Physician Marketplace Statistics, 1996.* Nationwide, physicians have an average of 11.2 managed care contracts.

Percentage of Employees by Choice of Plans Offered - California, 1996

	1 to 49 employees	50 to 199 employees	200 to 999 employees	1,000 or more employees	Total
One Plan Offered	66.4%	42.0%	21.9%	7.1%	45.5%
Two Plans Offered	29.9%	45.2%	38.9%	13.6%	31.5%
Three or More Plans Offered	3.7%	12.9%	39.3%	79.2%	23.0%
	100%	100%	100%	100%	100%

Percentage of Employees by Choice of Plans Offered - Nationwide, 1996

	1 to 49 employees	50 to 199 employees	200 to 999 employees	1,000 or more employees	Total
One Plan Offered	83.0%	67.4%	47.4%	13.0%	51.8%
Two Plans Offered	12.9%	24.4%	24.6%	14.3%	15.8%
Three or More Plans Offered	4.1%	8.2%	28.0%	72.7%	32.4%
	100%	100%	100%	100%	100%

Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.

The 1997 Kaiser/Commonwealth National Health Insurance Survey notes that, for families, choice of plans may occur through one's own employer, through one's spouse's employer, or a combination. Taking into account options through both spouse's employers would increase the proportion with choices. By this method the Kaiser/Commonwealth national survey found that 52% of all adults age 18 to 64 in working families have a choice of two or more plans compared to 36% with choices through their own employer.[9]

Those with no choice of plan are more likely to be working for smaller employers. In California 66.4% of employees working in employment groups of fewer than 50 employees had no choice of plan, compared with just 7.1% of employees in groups of 1000 or more employees. However, more than half of the working population in California work in small groups with between one and 49 employees. This is slightly higher than the national average. Small employment groups are important because they are more likely than large employers to have difficulty offering a choice of health plan and health care coverage at all. California has twice the proportion of covered employees in employment groups of 50 to 199 (18.1%) compared to 9.1% nationwide. Forty-two percent of these employees have no choice of plan.

Percentage of Employees by Size of Employer - California and Nationwide, 1996

[9] Davis and Schoen, 1997.

	1 to 49 employees	50 to 199 employees	200 to 999 employees	1,000 or more employees	Total
California	51.0%	18.1%	10.5%	20.5%	100.1%
Nationwide	46.9%	9.1%	9.5%	34.5%	100.0%

Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.

Even though Californians have greater choice of plans than the national average, fewer working Californians have access to a health plan that provides unlimited choice of provider than workers nationally. More than a quarter of working Californians whose employer provides health care coverage have access to only an HMO with a closed-end provider panel. In contrast, only 11% of workers nationally are offered only one health plan that is a closed-end HMO.

Percentage of Employees Without Choice, Offered HMO Only, as % of Total Population, California 1996

	1 to 49 employees	50 to 199 employees	200 to 999 employees	1,000 or more employees	Total
One plan only, HMO Only	34.5%	31.8%	11.7%	1.3%	25.3%
One plan only, but not HMO	31.9%	10.2%	10.2%	5.8%	20.2%
	66.4%	42.0%	21.9%	7.1%	45.5%

Percentage of Employees Without Choice, Offered HMO Only, as % of Total Population, Nationwide 1996

	1 to 49 employees	50 to 199 employees	200 to 999 employees	1,000 or more employees	Total
One plan only, HMO Only	20.0%	14.9%	5.5%	1.4%	11.0%
One plan only, but not HMO	63.0%	52.5%	41.9%	11.6%	40.8%
	83.0%	67.4%	47.4%	13.0%	51.8%

Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.

In addition, where employees have a choice of plan, it is often a choice of plan model type. This is positive in that some individuals in a group might prefer, for example, an HMO, while others prefer a PPO. However, choices among plan model types may not set up a very competitive situation among health plans because individuals are less willing to switch among them than among plans of the same model type.[10] For example, if an employee has a choice of two plans, but one is an HMO with, for example, $10 copayments and one is a PPO that, for example, requires members to pay 20% of costs after a deductible, an employee who is attracted by the low cost-sharing requirements of the HMO may not be willing to incur the extra cost to select the PPO even if he or she is unhappy with the HMO's service or provider panel. In California, only 28.7% of employees whose employer provides health care coverage has a choice of more than one plan of any coverage model type (i.e., HMO, POS, PPO or indemnity).

Percentage Of Employees Offered More Than One Plan of Any Plan Model Type (HMO, POS, PPO, indemnity), as a Percentage of the Total Population, California 1996

	1 to 49 employees	50 to 199 employees	200 to 999 employees	1,000 or more employees	Total
Offered One or More Plans, but Only One of Any Plan Type	85.8%	89.2%	54.7%	19.5%	71.3%
Offered More Than One Plan, and More Than One of the Same Plan Type	14.1%	10.8%	45.3%	80.5%	28.7%

Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.

III. OBSTACLES TO CHOICE

The reasons that individuals do not have greater choice are numerous and varied.

A. Individual Market

Individuals (not in groups) theoretically have an unlimited choice of coverage options, so long as they are willing to shop around for it and pay the market price. However, in

[10] Royalty, Solomon, "Health Plan Choice: Price Elasticities in a Managed Competition Setting", May 1997, forthcoming.

practice their choice may be much more limited due to reasons of access (e.g., plans often will not sell individual policies to unhealthy or high risk individuals).

Expanding access to coverage to unaffiliated individuals in a system of voluntary health insurance is a very difficult problem. Typically, those most interested in coverage are those who need coverage most. Those who are healthy are more likely to choose to forego coverage, opting instead to rely on the public safety net if necessary. This creates adverse selection and an upward spiral in premiums. In order to protect themselves against potential adverse selection, health plans serving this market rely on underwriting to identify costly individuals, raise premiums for the sick (perhaps to the point of unaffordability) or refuse to cover them at all. For the same reason, purchasing groups so far have not offered coverage to individuals. Short of a mandate that requires all individuals to purchase coverage, or a universal voucher that covers most of the cost of the low-priced plans and therefore gives even the healthy an incentive to buy coverage, viable solutions have not been found that would guarantee coverage to individuals. Federal laws, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provide for coverage of individuals who leave or change jobs and who wish to maintain continuity of their previous employment-based coverage.

Individual access to coverage is also less available than employees' access because federal tax law allows 100% deductibility of premiums to employers and 100% excludability for employees, but not individuals. However, the 100% deductibility and excludability of premiums has reduced employer and employee cost consciousness. In addition, an extension of this aspect of tax policy has been rejected by Congress because of its impact on the federal budget.

B. Employment Market

Unlike other nations and albeit with decreasing frequency even in the United States, the majority of Americans and Californians receive health insurance through their employment group. In 1973, Congress adopted the HMO Act which required most employers to offer a group practice and an individual practice HMO as choices where they were available and wanted to be offered. This ensured a choice of plans in employment settings until this aspect of the law was repealed.

Size of employer is an important determinant in whether employees have a choice of plan. Employers in the small group market typically offer choice of plan least often, as the tables above indicate. Reasons include: (1) some health plans refuse to participate in multiple choice situations with small employers, (2) employers face additional administrative burden when offering multiple plans, and (3) employers prefer to offer their whole group to one insurer in exchange for the best rates possible. This last strategy is short-sighted. Even if an employer achieves slightly reduced premiums for the first year or even two, as soon as the contract expires, their bargaining position is greatly weakened because it is very difficult to require an entire employment group to switch plans and perhaps providers. And, the employee dissatisfaction and potential

time lost from work to establish new provider relationships are unlikely to be worth the savings.

In 1993, AB 1672 established rules in the small group market such as guaranteed issue and renewal, limits on pre-existing condition exclusion periods, and limits on medical underwriting in response to problems of access to choice of plans. While some have suggested that an expansion of these rules to the mid-size market (groups of 51-100) would encourage formation of purchasing groups and ensure a wider array of choices to employment groups,[11] there is not a clear consensus that access to coverage options is a big problem in the mid-size market.[12] Such restrictions may reduce the current choice of product designs available in the mid-size market if health plans sought to avoid the requirement to distribute information on all products to all employers. In addition, increased regulation of health plans in this market could encourage more employers to self-insure, enabling them to avoid all state regulation of their health benefits.

IV. PURCHASING GROUPS

One way to expand choice of plans is to expand access to purchasing groups. Purchasing groups aggregate the buying power of many individuals or groups. In theory, they act like sophisticated benefits managers of large corporations for multiple employers. They facilitate multiple choice of plan at the individual or family level. Like large employers, purchasing groups can:

- achieve substantial economies in administration,
- set the rules to ensure equitable coverage of all persons in the sponsored group such as guaranteed issue and renewal,
- create and administer an open enrollment process,
- require individuals to bear full responsibility for premium differences,
- standardize benefit options within the group,
- provide comparative quality information,
- minimize the incentive and ability of health plans to select risks, and
- negotiate more favorable prices than could an individual employer.

California law distinguishes between two types of purchasing groups: purchasing alliances and marketing groups. Marketing groups, in general, act like purchasing alliances, but do not contract directly with plans or employers and do not transfer funds among them.

A. The Health Insurance Plan of California (HIPC)

The HIPC, established in 1993 through AB 1672, is a state-run purchasing alliance for small employers with between two and 50 employees, specifically designed to address the administrative problems small employers have in offering multiple choice (See Attachment Two: Purchasers). After three years of operation and steady growth, the HIPC covers approximately 130,000 employees and their dependents in California.

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[11] California Association of Health Underwriters, "Questions and Answers About CAHU's Position on SB-393/SB-1281, May 7, 1997.

[12] Industry representatives oppose expanding small group reforms for this and the following reasons.

While substantial, this number is very small compared to the more than ten million Californians working in small employment groups and their families.[13]

Theories abound about the reasons behind the limited growth of the HIPC. They include: (1) insufficient or inappropriate marketing effort; (2) lack of broker/agent support due originally to unattractive (flat rate) financial terms offered to broker/agents by the HIPC, now largely ameliorated. Currently, tension seems to stem from the HIPC's explicit reporting of the broker/agent fee, rather than incorporating fees into plan premiums as in the rest of the market; (3) purchasing groups are a new idea, the virtues of which may not be well appreciated or understood by many; and (4) the HIPC may offer too much choice which may be overwhelming to some.

B. Other Purchasing Groups

In addition to the HIPC, several other public and private sector purchasing groups have formed to service certain market segments. These include CalPERS which serves over one million public employees, retirees and their dependents, the Pacific Business Group on Health (PBGH) which serves large employers with more than 2000 employees and purchasing groups (including the HIPC and CalPERS) but is not involved in the administration of contracts between employers and plans, Benefits Alliance a newly formed marketing group for medium-sized employers with between 50 and 5000 employees in the ten-county bay area, and California Choice, also new, a statewide marketing group which competes with the HIPC. (See Attachment Two: Purchasers, for a more extensive description).

C. Prospects for New Purchasing Groups

With existing purchasing group activity, California has more employees in purchasing groups than any other state. However, despite this activity, purchasing groups are not available in many segments of the market.

Marketing groups that testified to the Task Force indicated that the regulatory hurdles are high to become a purchasing group through the Department of Corporations.[14] Challenges arise because employers contracting with health plans through a marketing group must contract with each plan separately, health plans participating in purchasing groups (as defined) can not jointly file coordinated documents with the regulatory authority, rather each plan must file separately, and participating plans are required to disclose to employers and employees details of all the benefit packages they offer even if an employer only provides coverage through a purchasing group which offers standard benefit packages.

To encourage the formation of new purchasing alliances and to set certain financial solvency and consumer disclosure criteria to which they must comply, Senator Peace sponsored Senate Bill 1559 which was enacted in 1997. Under the new law, any

[13] Estimate, based on "United States–Employees, Payroll, and Establishements, by State: 1993", *County Business Patterns*, Department of Labor, Bureau of Labor Statistics, 1993

[14] Testimony presented by and received from Benefits Alliance and California Choice.

purchasing alliance, with the exception of the HIPC, must be obtain a Knox-Keene license or certification by the Department of Insurance (DOI). They may be either for-profit or non-profit entities, trusts, partnerships, or sole proprietorships, but no owner, officer, partner, board member, or manager of a purchasing group may be affiliated with an agent or broker. While this prevents potential abuse by agents and brokers who could exclude unhealthy groups from the purchasing group, it also deters those with the most knowledge and likely the greatest interest in forming purchasing groups. Also, under the new legislation, the DOI is required to make a determination concerning the application to become a purchasing alliance within 180 days of the application date. So far, only one purchasing alliance has applied for certification.

The requirements established by the Peace bill do not apply to marketing groups. New marketing groups would continue to obtain approval through the Department of Corporations (DOC).

V. TASK FORCE RECOMMENDATIONS

While expanding consumer choice is a widely-supported goal among task force members and the public, there is little consensus about how to accomplish it.

A. Ways to Expand Choice of Plan

Studies show that people with a choice of plan are more satisfied with their insurance and their doctor, and with the services they receive. Choice of plan also permits a wide choice of providers and makes it more likely that individuals can maintain a relationship with a particular provider if their job status changes. In addition, choice of plan enables competition to work to discipline price.

Change ERISA to Require Employers to Offer Choice

One way for the State to address the problem of the lack of individual choice would be to require employers over some size (e.g., 25 employees) to offer choices, as the federal government did in 1973 through a now-expired provision of the Federal HMO Act. States, such as Maryland, have been trying to do so, but have been blocked by the federal Employee Retirement Income Security Act of 1974 (ERISA) in which the federal government has preempted state regulation of employee benefits.

(1) The Task Force recommends that the US Congress create a new law, like the provision of the original HMO Act, that requires employers to offer choice of plans, which may be satisfied by purchasing through a purchasing group, or modify ERISA to allow California to do so.

Establish Rules Regarding Minimum Participation Requirement

Today, many health plans effectively prohibit some employers, typically small employers, from offering a choice of plans by imposing minimum participation requirements. In other words, a health plan carrier can require that at least, say, 70% of an employers' employees join its plan (i.e., choose one of the products the plan offers through that employer). Health plan carriers employ this policy, in part, to protect themselves from any potential harmful effects of adverse selection within the group.

However, this strategy also prevents employees of small employers from having a choice of plans. Current law (AB 1672) combats blatant use of minimum requirements for the purpose of skimming healthy enrollees by requiring health plan carriers to consistently apply their minimum participation policy.

(2) The Task Force recommends that the State prohibit health plans serving the small group market from setting minimum participation requirements for participation in their plans, thereby effectively declining to participate in multiple choice situations.

(a) Instead, an aggregate participation requirement for all carriers offered should be permitted to protect against adverse selection.

(b) This recommendation should only be implemented to the degree that negative consequences such as increasing prices or skimming can be avoided. For example, it may not be appropriate to apply the recommendation in cases where an employer selects carriers that do not offer the same product types (i.e., HMO, PPO, etc.) and where the benefits are not reasonably comparable.

(c) This would not prohibit an employer from offering one plan only (though Recommendation (1) above would).

(d) Nothing should prohibit a health plan from offering a higher price than it would for covering a higher proportion of an employer's group, nor from offering a higher price to a smaller group, within current rating laws.

B. Ways to Expand Purchasing Groups

One way to expand choice of plans is to expand access to purchasing groups. Recommendations include:

Simplify the Regulatory Approval Process

(3) The Task Force recommends that the State should make it a matter of public policy to facilitate and encourage the development of purchasing groups for small and medium size employers. The applicable regulatory authority should work continuously to simplify the process of and eliminate barriers to purchasing group formation. Appropriate measures for the DOC and DOI may vary.